## ***Concurrent Session One – Use of Data/Fostering Buy-In***

***David Napp, Facilitator***
***Practical Applications for Public Health***

David Napp acknowledged that there are some ways that the Guidance might be an annoyance, and there are things that could be improved in it. He explained that this session would be focused on solutions and on how to make the Guidance better. He then initiated a discussion about issues regarding getting buy-in to evaluation, pointing out that not only might there not be buy-in in the field, but also that some health departments themselves may not be supportive of data collection as specified by the Guidance. He asked the group to consider and give input to the following questions:

- ❑ What happens if you or your providers are not sold on the idea of evaluation?
- ❑ What makes it difficult to get buy-in?

***Discussion Summary:***

- ❖ It was noted that capturing only the minimum requirements to get the "check to clear" probably will mean that the data will not be very useful.

- ❖ A participant from Texas commented that they had begun process evaluation early on so that contractors were involved in the data collection process. Data quality has improved for them with acceptance of the Guidance. At the state level, they can identify providers that are comfortable with the data as well as providers that need help. He also said he appreciated being able to provide his contractors with specialty reports, such as specific information about populations such as African-American men. Contractors can compare themselves with the rest of the state, and CPGs are seeing the evaluation's effectiveness.

- ❖ A participant from New Jersey observed that non-acceptance can be at a different level. If state-level bureaucrats do not buy into the idea of evaluation, then the entire process will be made more difficult because there will be problems with trying to purchase the proper hardware and software. Also, program monitors must buy in, as they coordinate the activities with the CBOs. Without their full support, data will not come in on a regular basis. At the agency level, there must be ownership of the data, or else there will be issues with data quality, compliance, and other areas.

- ❖ It was noted that buy-in starts with the people who are doing interventions. One problem is that many of them only want to do their interventions and do not want to collect data.

- A participant from Arizona related a challenge with their CBOs, which is that they are afraid that the data will disagree with what they think is happening, and they do not want to know that. They are also wary of comparing their data with other agencies.

- A participant from New Jersey said that a key reason for resistance was a fear from the CBOs that the data would be used against them somehow. There was concern that they might lose funding.

- People also have concerns about not having the expertise or the background to collect information, said another audience member.

- David Napp observed that in his experience, many agencies conduct evaluation-type activities, but do not call them "evaluation."

- A representative from New Mexico indicated that in New Mexico, there is a distrust of government in general. The data that CDC or the state health department wants to gather is not always the data that the local agencies want to gather, specifically in dealing with special populations. Other participants echoed concerns about the Native American population. There are also discrepancies between cases that are reported to the state epidemiologist and cases that CBOs collect, which results from a mistrust of the government.

- There is also an administrative problem, said an audience member. The "it's not my job" attitude from field operations pervades, and many agencies do not understand that they cannot be monitored if they do not conduct evaluation.

***Gary Novotny***
***Health Department Peer***
***Minnesota Department of Health***

Gary Novotny shared his experiences with fostering buy-in in Minnesota. He said that fostering buy-in is probably the most important criteria in a successful evaluation project because it is a constant activity. In his state, they look at the process as a continuous cycle (e.g., gathering data, using the data, and feeding the data into fostering more buy-in with existing and new players).

In the early 1990's, Minnesota was completing basic program monitoring reports. There were questions about how the data was being used, from both CBOs and at the state level. Other state agencies were embarking on evaluation projects, so their Division felt that they should conduct some program monitoring. They created an RFP to hire an evaluation consultant, and got two consultants.

Before creating an evaluation plan or tools, the consultants advised working in the field to identify the project players and assess what they needed. Building and continuing rapport was an important first step in the strategic process toward getting buy-in. They next developed evaluation plans individually with agencies, and the agencies began working with the very basic plans and tools. They realized that the process would be marked by trial and error. The state department provided a yearly training on the basics of evaluation research.

His contract managers played an important role in the process, working with individual grantees to understand program results via their data reports. They used the data to assess program progress and to identify any program changes. They developed a "progress record," which summarized their thoughts and observations about the agencies' data and acted as the basis for their feedback to the programs. The cycle is completed because buy-in is beginning, or intact, with the programs. Instead of using the phrase "use of data," they use the phrase "using the evaluation results." Having data is but one part of the process. The data must then be analyzed and considered to be used.

Ultimately, they engage in evaluation because they want to stop the epidemic. The evaluation project is about the clients. In using the evaluation results, Gary Novotny and his staff incorporated the following concepts:

- ❑ Conceptual use, which involves thinking about the results;
- ❑ Integrating the results with other program information;
- ❑ Communicating the results with CBOs, funders, boards of directors, CPG's, other staff at the agency who work in other programs, and others;
- ❑ Remembering the role of clients, which includes asking them about their satisfaction with the programs offered – one program even brought data back to the clients;
- ❑ Persuasive use, which uses results to propose more funding from other sources and to convince others of the program's merits, incorporating the accountability aspect of the program; and
- ❑ Instrumental use, which can help decide whether to continue, change, or improve a program or an intervention.

***Dale Stratford***
***CDC Representative***
***Ways that CDC Uses the Data Reports***

Dale Stratford listed the ways in which CDC uses the data reports from the HIV prevention programs which include:

- ❑ Accountability to Congress, which is important because it affects funding to CDC;
- ❑ CDC is committed to using the data both in feedback to the state health departments and in national planning;
- ❑ Patterns of interventions that are being utilized, whether they are based in research or based in other evidence, such as program experience, are noted. Patterns of promising interventions may lead to more programming emphasis; and
- ❑ Agencies are collecting more information than the Evaluation Guidance requires, and so CDC is looking at other ways to collect that in-depth, quality information.

***Discussion Summary:***

- ❖ Tomas Rodriguez commented on findings in San Francisco regarding young MSMs. Since CDC is as national agency, they were able to see similar problems in other areas in the country and share that information with the local agencies.
- ❖ A participant commented that at present, there is not enough linkage between the data that is collected for the Evaluation Guidance and the Program Narrative. She advocated for training for CBOs and health departments in how to interpret the data.
- ❖ David Napp commented that perhaps the forms should be rearranged so that grantees can include a narrative after reporting the numbers for an intervention, which would encourage them to talk about the data immediately.
- ❖ Tomas Rodriguez mentioned a PCM program that was only seeing five people a month, but because of cultural issues, there was no way to get more people. Information like that can only be translated in a narrative and illuminates the numbers.
- ❖ David Napp added another way to use data for intervention plans is that agencies are required to report the number (and demographics) of people that are anticipated to be served, so past experience can inform these projections.
- ❖ A participant asked what Congress looks for from CDC and the NIH and how the data is given to them. Dale Stratford replied that Congress is mainly interested in how money is being spent, for what kinds of populations and interventions, and how effective the programs are. The funding allocation process is not as simple as following the data, she

said, because of special interest groups and other factors.

- An audience member wondered whether Congress ever questions why HIV continues to rise, despite the money that is spent on it. Tomas Rodriguez replied that they do, and that he has to go to a meeting to justify the actions of a single program. Data is proving that the epidemic is being stopped in some ways, he said, but proving that is difficult.

- A representative from New Jersey described his state's interest in geo-mapping. They have a variety of administrative and epidemiological data within the state health department from a variety of programs and activities. Prevention was an area in which the simple questions, such as where the money is going and what is being achieved, could not be answered, he said. The Evaluation Guidance has forced them to think in that direction and to collect process data. He hopes to use that data to contribute to a comprehensive picture of efforts in the state.

- Dale Stratford said that there are excellent examples of innovative uses of data to develop program strategies. In Maryland, for instance, they are using many kinds of data to feed back into the strategizing process. A representative from Maryland described how they are using different kinds of information for site selection for their mobile van for HIV testing and STD treatment. They have a committee of people that are collecting STD data, police sweep and crime data, and other HIV-related data to help make decisions about where and how long to site the van.

- A New Jersey representative commented on the perinatal prevention work as an excellent example of how data can work together. They overlap data county-by-county to find infants who are infected with HIV.

- A participant commented that for specific activities, combinations of data can be effective; however, for general prevention activities and PCM programs, they cannot show outcomes so specifically. David Napp acknowledged the risk of "knowing just enough to be dangerous."

- Another participant pointed out that MSMs, particularly high-risk MSMs, are not organized in a way that they can be reached and screened such as, for instance, pregnant women. Their prevention grantees need to think about that, he said. IDUs have similar problems. Outreach and prevention workers have to work hard to reach these populations, because the "cooperative" people at risk that are being reached by most efforts are not as at-risk at these other, more difficult to organize populations.

***David Napp, Facilitator***
***Group Exercises***

David Napp then directed the group to break into smaller groups during which they were to reflect on solutions to the problems that they had listed, as well as other problems that they may have. He encouraged them to name three strategies that they could use in their jurisdictions to combat the difficulties, whether they were new ideas or strategies that have been in place. He suggested that they think of it as designing an intervention to change the norms in their jurisdictions about how evaluation is perceived. Following the breakout sessions, the groups reported on their input to the questions:

**Question #1**

*What are some of the ways to address challenges to getting buy-in to evaluation so that you increase buy-in to evaluation in your jurisdiction?*

***Discussion Summary:***

- A participant addressed how to get buy-in from the people who are receiving the intervention. In rural areas in particular, just getting the information from the clients is difficult. Feedback to the client is a way of getting participation at that level. Feedback to the CBO can help as well, especially data that they can use to write grants for more funding or to prove that they are doing what they said they would do.

- Another group suggested not using the word "evaluation," because it can make people nervous. One of their members commented that representation on the CPG is dominated by CBOs and contractors, so training at the CPG level can take information back to the agencies.

- The translation issue is important, commented a participant from Texas. He has been examining their contract monitoring tools and reinforcing that his agencies are already doing many of the activities required by the Guidance, but they are reorganizing it in different categories. They have built trust in the health department by holding community meetings and discussions. Populations understand that public health is there to stop the epidemic, not for political reasons. Making this goal clear has improved all relationships.

- The representative from New Jersey stressed that it is a slow process. If they approach the evaluation work from the perspective of helping to manage programs better, then there will be more buy-in. His department set up regular meetings with CBOs so that they can all talk and trade ideas. He has learned about their needs, and he noticed that they wanted to collect more data than he needed. He also discovered that capacity is a large problem. One agency did not even have an e-mail service; therefore, he has built technical capacity into their grant monitoring process. He has worked slowly to get them

comfortable with electronic media.

David Napp agreed that the process is time-consuming, like any intervention, and since the Guidance is already out, there can be pressure on the health departments. The group then pinpointed some common themes in the offered solutions:

- ❑ Two-way communication between the state health department and the individual CBOs;
- ❑ The mutual benefits of trust, relationship-building, and credibility of the community and the government;
- ❑ Reliability of data;
- ❑ The time that the process takes;
- ❑ Relying on the fact that people really want to do a better job fighting the epidemic; and
- ❑ CPGs are asking for more data (and there is an element of mistrust there: re-framing the task to ask for data that will help them rather than for evaluation will help).

**Question #2**

*What are ways to use evaluation data in your jurisdiction?*

***Discussion Summary:***

- ❖ The first group discussed Texas's approach, which is using process data from their new prevention counseling form along with the epidemiological profile morbidity data to plan for target populations and priority-setting. They use that information with local needs assessment and other local information to help set priorities. They also use client feedback to help understand risks and help their CPGs understand populations that are being served. They are also generating special reports and getting the information back to contractors so that they can not only see the information, but also see how it is being used and how they can use it better. The contractors see better value in the information if it is theirs.
- ❖ David Napp asked the group how many people were planning to use or were already using Guidance or other evaluation data to feed into their community planning process. He asked them to list other ways that they are using data in community planning other than to understand risk populations.

- A participant replied that it was acting as their resource inventory. CBOs can use the combined reports to get a sense of their area, using that information in their evaluation reports. David Napp commented that in his work in national technical assistance with community planning groups, he focuses on priority-setting, which includes doing a resource inventory and being able to say "who is doing what for whom."

- Another participant considered using the data to examine the feasibility of using an intervention for a given target population. If an agency wants to do a certain intervention with a certain population, process data can help them focus their efforts. Numbers of people reached can be particularly helpful.

- A participant asked how to use the member surveys and the co-chair surveys, which are part of the Evaluation Guidance. Another participant suggested using that information in the progress report to CDC which has to report on the core objectives of community planning. One of those objectives is to illustrate that the CPG is representative of the population served and has the appropriate expertise. David Napp added that if they see that their membership is lacking, then the recruitment committee can assist.

**Question #3**

*What are other ways that evaluation data can be used?*

***Discussion Summary:***

- It was noted that other agencies' reporting requirements can be fulfilled.

- In Maine, they do performance-based contracting, which incorporates outcome measures. In their annual report, they combine their demographic information with outcome information and report it by agency as well as in an aggregate form. Agencies can see how they are doing, and then the data can be used in the renewal process and to raise the bar on their projections.

- Contractors that get local funding use state forms to report to those agencies to prove their needs and to ask for more funds and support.

- Data collection can be like a mini-assessment within an agency, so if more things are recorded than CDC asks for, such as referrals, then the needs of the clients can be better documented and used to get more funds.

- If other agencies have been more successful, then their evaluation results can be used to adopt their approaches.

- One state asked their grantees how they were using their data and discovered that the most frequently reported use was for grant-writing. Other ways included internal sharing and reporting, for other external reports for other funders, and for publication. They also used the data to monitor accomplishments of goals internally and to improve or change their programs.